TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Martin Jones, M.D.

Respondent Name
Hartford Insurance Company of Midwest

MFDR Tracking Number
M4-15-4179-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the payment issued to us does not meet the recommended allowance for the services performed, as dictated by the Texas Medical Fee Guideline."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider only billed only diagnosis code: 924.11 – Contusion of knee and payment for $1450 was processed as follows: …

- CPT 99456 MI – Multiple impairment ratings - **$50**

Per the medical notes submitted by the provider, there was only one muscoskeletal body area affected which was the lower extremity. There were no other body areas affected, so reimbursement is based upon one unit."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2015	Designated Doctor Examination (Multiple Impairments)	$50.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
   - 247 – A payment or denial has already been recommended for this service.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed service?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While the requestor included charges for Maximum Medical improvement (MMI), Impairment Rating (IR), and Extent of Injury (EOI) on the Medical Fee Dispute Resolution Request (DWC060), they are seeking $0.00 for these charges. Therefore, they will not be considered for this dispute. The dispute involves a charge of $50.00 for CPT code 99456-MI, for Multiple Impairment Ratings.

   28 Texas Administrative Code §134.204 (j)(4)(B) states,

   > When multiple IRs are required as a component of a designated doctor examination … the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

   The submitted documentation indicates that the Designated Doctor was ordered to address MMI, IR, and EOI. The narrative report and enclosed forms support that these examinations were performed, and one additional impairment rating was provided. Another additional Report of Medical Evaluation was provided, but the requestor found that the injured employee was not at MMI, so no IR was provided for this report. Therefore, the correct MAR for this service is $50.00.

2. The total MAR for the disputed service is $50.00. The insurance carrier paid $50.00. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	September 21, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.